

# Hospital FFS Claim Appeal (1<sup>st</sup> Step)

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## Appeals

Policy: [Medicaid Provider Manual](#) (MPM) Chapter “General Information for Providers”  
Section 17 Provider Appeal Process

[MPM](#) Chapter “Hospital” Section 12 Appeals

**\*This provider tip is only in reference to fee for service Medicaid providers, appeals for any other payer must follow that entities appeal process\***

Most appeal matters begin with a claim denial or other form of negative action made by MDHHS. It is highly recommended that prior to undertaking the administrative burden of filing an official appeal with the Michigan Administrative Hearing System (MAHS) that providers contact Provider Support to have the issue reviewed. Most times there are simple billing errors or processing errors that can be resolved without an appeal.

Outlined below are the general area's that need to be reviewed by the provider prior to requesting a formal appeal:

1. Review your claim. Review the CARC's and RARC's and their definitions available on the [WPC](#) website to determine how the claim was processed. If errors are identified then the claim will either need to be resubmitted or adjusted to reflect the correct information for proper adjudication. Only paid claims can be adjusted
2. If you feel the claim has paid incorrectly refer to the provider tips on pricing hospital claims for assistance in determining how reimbursement was calculated  
[Outpatient Claims](#)  
[Inpatient Claims](#)
3. If your Inpatient claim is being denied for a PACER or Prior Authorization review the [PACER requirement](#) or the [ICD-10 Surgical Code requirement](#) tips.
4. If your Outpatient claim or service line is being denied for Prior Authorization. Refer to the [Medicaid Code and Rate Reference Tool](#) within CHAMPS external links to identify which service requires a PA. You must work with the MDHHS Program Review Division to obtain PA under the facility NPI.
5. If your claim is denied for timely filing review the claim history in CHAMPS to determine if the claim was kept active per policy requirements. Refer to the [Timely Filing Provider tip](#)

6. If your claim is denied for predictive modeling audit you will need to review the services billed and compare to the medical records submitted. More detailed information can be found in the [Predictive Modeling provider](#) tip
7. If your claim is denied or incorrectly paid for other insurance review your claim in CHAMPS and compare to the primary payers eob to ensure the information is accurate. If CHAMPS system shows incorrect coverage, then a request needs to be submitted to update the system using the online form [Update Other Insurance Now](#)

After reviewing the above steps and there still remains a dispute you will need to contact Provider Support in writing by either email [ProviderSupport@Michigan.Gov](mailto:ProviderSupport@Michigan.Gov) or by mail:

MDHHS/Provider Inquiry

PO Box 30731

Lansing, MI 48909-8231

Please provide the providers name, address, phone number, and email address

Suggested Materials to submit for review

- Any claim identification information
  - RA
  - TCN
  - Beneficiary ID
  - NPI
  - Dates of Service
  - Service Request Number (s)
  - EOB
- Clearly specify what the dispute is and provide any supporting evidence. Normally medical records are NOT necessary
- A Provider Consultant will review your materials and make a determination
  - If the negative action is upheld then you will be sent a letter of position along with the next level of appeal rights.
  - If it is determined that the claim was adjudicated incorrectly a Provider Consultant will contact you for reprocessing details/instructions